Geisinger Health Plan Outpatient Rehabilitative Therapy Services Network **FORM A**
OUTPATIENT REHABILITATIVE THERAPY SERVICES REFERRAL FORM **(New Case)**
Phone: (570) 271-5301 Toll Free: 1-800-270-9981 Fax: (570) 271-5302

SECTION 1 **– (to be completed and faxed upon initial visit) *Required information. Incomplete forms will be returned unprocessed**.

Member Information	**Referral Source**	***Rehab Provider Facility Name**
*Last Name, First Name, MI:	Referring Physician *First Name, Last Name	Location: *Health Plan Provider #:
*DOB: Address:	*Phone: ( ) *Fax: ( )	*Phone # *Fax #:
Phone #: *GHP ID#:	*Service Requested PT ☐ OT ☐ ST ☐	*Site of Service: O/P Clinic ☐ SNF ☐ Hospital ☐ CORF ☐ Assisted Living Facility ☐

OTHER INSURANCE INFORMATION: (Workman's Compensation, Auto Insurance, etc.)
Company: Policy Number: Claim Number: Date of Accident:

Contact Person: Phone Number:

DIAGNOSIS INFORMATION

*ICD-9 CODE: *DESCRIPTION:

SURGICAL PROCEDURES: (Include Dates) Co-Morbidities:
Psychosocial Factors:

SECTION 2 **–**
Functional level prior to current problem: _____

_____

Current Problems/Duration: (Include specific Clinical Information) Or ☐ Eval attached /or 1 visit only Requested☐

_____

_____

_____

_____

_____

Goals:
1. _____
2. _____
3. _____
4. _____
5. _____

Plan of Care: _____

Therapist Signature: _____ Date: _____

For Geisinger Health Plan Outpatient Rehabilitative Services Network Only

Authorization #:	# of Approved Visits:	Discipline authorized: PT OT ST

Approval verifies appropriateness of a level of care and is not a guarantee of payment.

Case Manager Signature: _____ Date: _____